EXHIBIT B

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Licensed Psychologist

Marie Neubauer
Test Accommodations
ACT Test Administration
301 ACT Drive
Iowa City, IA 52243

1-31-12

Dear Ms. Neubauer:

You asked me to review documentation pertinent to an appeal for nonstandard test accommodations on the ACT (Plus Writing) exam. The applicant, [redacted] is requesting extended time (50%) for all sections of the exam. These requests are based on diagnoses of a Cognitive Disorder and Reading Disorder. Documentation to support this request includes:

a) application form;
b) personal statement;
c) psychological evaluation reports from Ann Marcotte, Ph.D. (2007, 2011) and letters to [redacted] (2009) and to ACT (2012);
d) standardized test scores from [redacted] (8th grade);
e) educational plans from [redacted] (2010-2012);
f) letter from lawyer, Charles Weiner;
g) letter from the College Board approving 50% extended time for the SAT.

The history as documented in the two psychological reports from Dr. Marcotte suggests that Ms. [redacted] received small group reading support in first grade. She was referred for an evaluation that was completed in 2001 (age 6y, 8m) by Dr. Luallen. The report is not in the file. Reportedly, Dr. Luallen diagnosed Ms. [redacted] with a Learning Disability. Because this report is missing and there are no school records from that time period, it is unclear what exactly was determined, and what services may have been provided. Dr. Marcotte reports that Ms. [redacted] worked with a tutor outside of school and was able to bring her skills up to grade level. By third grade some problems with math were noted. She transferred to the [redacted] in 5th grade, and was evaluated by Dr. Marcotte in 7th grade.

Results of the testing revealed a WISC-IV IQ score of 103, with index scores ranging from 106 to 108, except for Processing Speed (80). Processing speed consists of simple visual-motor tasks that require redundant responses in a short time period. It appears that Ms. [redacted] had a low output of responses during these timed tasks. Achievement test scores on the WIAT-II also were strong (107 to 120) except for Math Fluency (79). Math Fluency also requires simple math responses in a short time period. Again, Ms. [redacted] had a relatively low output within the short time frame. The WIAT II reading composite score was 116. Informal measures of reading on the WIAT II

suggested high average word fluency and low average reading fluency. Additional neuropsychological testing revealed performances within normal limits in the areas of language, visual spatial/perceptual ability, visual-motor integration, motor skill, memory, verbal learning, and executive functioning. There were a couple of weak scores in the profile, particularly on the continuous performance test. In general, a few low scores on a neuropsychological profile that involves 70 scores would be considered normal. One would expect a few low scores by chance in a battery of that many tests. Dr. Marcotte argued that Ms. [redacted] low scores tended to be on tests that required speed, and that she seemed to have a significant weakness relative to same age peers with regard to cognitive processing speed. Dr. Marcotte said that this pattern of weaknesses is consistent with a diagnosis of Cognitive Processing Disorder NOS. She recommended that Ms. [redacted] receive extended time for timed tests.

In my opinion, Ms. [redacted] does appear to have her lowest performances on timed tests. It does not matter if the task is math, reading, coding symbols, or finding targets. If you ask her to perform on a speeded task she performs less well relative to her other performances. The question is why this occurs? Could it be that Ms. [redacted] has a methodical work style, does she sacrifice time for accuracy, is this a habitual way she performs on timed tasks, does she get anxious on timed tests, or does she have a physical disorder as noted by Dr. Marcotte? A diagnosis of Cognitive Disorder NOS is based on the physiological effects of a general medical condition (i.e., cancer, AIDS, etc.) or a central nervous system dysfunction (i.e., head injury, multiple sclerosis). To my knowledge, there is no evidence that Ms. [redacted] has any such condition. To be quite honest, this diagnosis is surprising to me because it does not seem appropriate. We use this diagnosis with our head-injured patients, but not with persons having no positive medical history and essentially normal neuropsychological profiles. While I understand the desire to describe Ms. [redacted] relative weaknesses on timed tests, I just see no evidence of an organic pathology that would underlie her performance. Interestingly, there supposedly was a diagnosis of LD in first grade, yet no school records, nor the 2007 report, mention LD as a diagnosis. However, in a 2009 letter Dr. Marcotte wrote to the [redacted] she refers to learning problems, a previous LD diagnosis, and recommends that Ms. [redacted] be exempt from taking a foreign language.

Dr. Marcotte next re-evaluated Ms. [redacted] in October of 2011. In reviewing her 2007 report she says that Ms. [redacted] was "re-diagnosed with a Learning Disorder" and that "she presented with residual features of a Reading Disorder." I am not sure what she means by "re-diagnosed." This is quite confusing and to say the least unconventional in clinical work. It becomes extremely important in this case, because Dr. Marcotte is the only person in the file to have evaluated Ms. [redacted] and make a diagnosis. The entire case is based on her opinion, with no corroboration from other professionals. If she changed her mind or added diagnoses four years later, that is significant and warrants discussion.

Dr. Marcotte's 2011 report goes on to show a WAIS IV IQ score of 113 with index scores ranging from 97 to 119. The Processing Score that was 80 in 2007 is now a solid 97. It shows the level of error in testing and why we must be careful not to jump to conclusions from a test score. All other cognitive scores tended to be within normal

limits. Achievement test results on the WIAT III once again revealed average to superior scores with no score below average. In fact, the Math Fluency score (95) also increased dramatically from the 79 recorded in 2007. It is interesting that two of the lowest scores and bases for a diagnosis in 2007 have increased so dramatically and are now solidly average. It is also noteworthy that the Reading Fluency and Comprehension composite score was 112 and the Written Expression composite score was 118. These would be skills required for the ACT exam and they are quite strong. Dr. Marcotte administered a volume of additional tests. Some low average performances were noted on Rapid Naming, Nelson Denny Reading Test, copying the Rey figure, Trail Making Part B, and parts of the Conner's continuous performance test. In a sense, Ms. [redacted] has a somewhat improved test profile from 2007. However, Dr. Marcotte maintained a diagnosis of a Cognitive Disorder NOS and added a diagnosis of Reading Disorder. This diagnosis seemed to be based on residual weaknesses in decoding and a slower than expected reading rate. Interestingly, Ms. [redacted] obtained her highest 8th grade achievement test score (93 %ile) on Reading Comprehension as compared to her Algebra score (0 %ile). It is surprising that this did not weigh in the interpretation of a Reading Disorder. Based on everything I have seen, it appears that math is a relative weakness and most reading scores are quite good.

As argued earlier, I do not agree with a diagnosis of Cognitive Disorder. There is no evidence of any medical or organic condition that would cause significant cognitive problems for Ms. [redacted] In addition, the improved scores on some of the timed tests repeated in 2011 further support the notion that Ms. [redacted] does not have a cognitive disorder. It also appears that Ms. [redacted] does not have a reading disorder. Her reading test scores are generally strong. The only weak reading score is on the Nelson Denny and that is not really a diagnostic test. It has poor psychometric properties and norms and was developed to be a group placement instrument. To overlook other sound measures and rely on the Nelson Denny scores is not prudent in my opinion.

It seems clear that Ms. [redacted] does not have a cognitive disorder nor is she substantially limited in reading. It does appear that she is likely to have more problems on some timed tests under certain conditions, and even these performances appear to be low average. Neither a Cognitive Disorder nor Reading Disorder explains the general weakness on speeded tasks. It seems very possible that Ms. [redacted] is wired this way. She tends to work deliberately and successfully on most things. She is challenged when she has to do tasks in a hurry. Whether this is variation of normality or something more seems to be unclear. It certainly is not a function of a Cognitive Disorder as defined by DSM IV.

If Ms. [redacted] has some form of learning disability, the documentation in the file is lacking in support of it. Where is the 2001 evaluation report with an LD diagnosis, where are school records indicating LD, where are the teacher notes, grades or standardized test scores that support LD impairment, why is a Reading Disorder re-diagnosed years after an evaluation, and why is a Reading Disorder diagnosed even though most reading scores are average or better in two evaluations and a national standardized test? This case and the diagnoses seem to be based on one person's opinion, Dr. Marcotte's, which seems to

have changed some over the years. I believe it would be helpful to have the other information suggested above in order to confirm or refute Dr. Marcotte's opinion. I do not believe that the documentation provided, essentially two reports from Dr. Marcotte, prove either diagnosis that she has made, and I do not see evidence of a substantial limitation in reading based on standardized, acceptable measures of reading. Without clear evidence of a disability that includes a limitation in a major life activity, I believe that test accommodations are not yet justified. Perhaps the applicant can provide the 2001 report, school records showing LD identification prior to Dr. Marcotte's 2011 report, additional standardized test scores, school grades and evidence of reading problems, and other materials that support a diagnosis of Reading Disorder and how it substantially limits Ms. [redacted] I would be happy to review a complete file should such documentation be forthcoming.

Sincerely,

Lawrence Lewandowski, Ph.D.
Licensed Psychologist